STATE APPLICATION INDIANA CONTROLLED SUBSTANCES REGISTRATION

State Form 34617 (R11 / 6-97)
Approved by State Board of Accounts, 1996

Health Professions Bureau
402 West Washington St., Rm. 041
Indianapolis, IN 46204

For official use only
CSR No.
Receipt No.
Issuance date
Approval / Iss Coord.

Please refer to the enclosed instructions **before completing** for **applicable fee** and information.
Please type or print all information

PRACTITIONERS

(Please check one box)

☐ Dentist ☐ Physician ☐ Osteopathic Physician ☐ Podiatrist ☐ Researcher ☐ Veterinarian ☐ Advanced Practice Nurse

Name of practitioner		Indicate speciality	
Telephone number	Professional License number	Date of birth	Social Security number *

Name of Facility *(if applicable)*

* Your Social Security number is requested by this agency in accordance with IC 4-1-8-1, and it is not mandatory that it be given. Social Security numbers are available to the Indiana Department of Revenue.

Indiana practice address *(may **not** be a P.O. Box)*

City, State, Zip Code

Drug schedules: *(Check all applicable)*

☐ 1 ☐ 2 ☐ 2 Narcotic ☐ 3 ☐ 3 Narcotic ☐ 4 ☐ 5

If your answer is **Yes** to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a registration issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit that you hold or have held? ☐ Yes ☐ No

2. Have you ever been convicted of, pleaded guilty or *nolo contendere* to:
   a. A violation of any federal, state or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   b. To any offense, misdemeanor or felony in any state *(except for minor violations of traffic laws resulting in fines)?* ☐ Yes ☐ No

APPLICATION AFFIRMATION I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.	Signature of practitioner	Date

NON-PRACTITIONERS

(Please check one box)

☐ Pharmacy ☐ Hospital / Clinic ☐ Surgery Center ☐ Wholesale Distributor

☐ Analytical Laboratory ☐ Manufacturer ☐ Teaching Institution ☐ Other: _____ *(Please specify)*

Name of Facility

DBA *(if applicable)*

Pharmacy manager or Person responsible for controlled substances

Address *(may **not** be a P.O. Box)*

City, State, Zip Code

Drug schedules: *(Check all applicable)*

☐ 1 ☐ 2 ☐ 2 Narcotic ☐ 3 ☐ 3 Narcotic ☐ 4 ☐ 5

If your answer is **Yes** to any of the following, explain fully in a signed and notarized statement, including all related details. Include the violation, location, date and disposition. Letters from attorneys or insurance companies are not accepted in lieu of your statement. Falsification of any of the following is grounds for permanent revocation of a registration issued pursuant to this application.

Has the applicant, any of the agents or listed pharmacist ever been convicted of, pleaded guilty or *nolo contendere* to:

   a. A violation of any federal, state or local law relating to the use, manufacturing, distribution or dispensing of controlled substances or drug addiction? ☐ Yes ☐ No
   b. To any offense, misdemeanor or felony in any state *(except for minor violations of traffic laws resulting in fines)?* ☐ Yes ☐ No

APPLICATION AFFIRMATION I hereby swear or affirm under the penalties of perjury, that the statements made in this application are true, complete and correct.	Signature of applicant	Date